Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS4847AGC	A. BUILDING _____ B. WING _____	11/20/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALEBRIS HOME CARE INC	1012 PARADISE VIEW STREET HENDERSON, NV 89052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments Surveyor: 28380 The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted in your facility on 11/20/09. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility received the grade of B. The facility is licensed for ten Residential Facility for Group beds which provide care to persons with Alzheimer's disease, Category II residents. The census at the time of the survey was ten. Ten resident files were reviewed and six employee files were reviewed. One discharged resident file was reviewed. The following deficiencies were identified:	Y 000		
Y 103 SS=F	449.200(1)(d) Personnel File - NAC 441A / Tuberculosis NAC 449.200 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (d) The health certificates required pursuant to chapter 441A of NAC for the employee.	Y 103		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS4847AGC	A. BUILDING _____ B. WING _____	11/20/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALEBRIS HOME CARE INC	1012 PARADISE VIEW STREET HENDERSON, NV 89052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 103	Continued From page 1 This Regulation is not met as evidenced by: Surveyor: 28380 Based on record review on 11/20/09, the facility failed to ensure 1 of 6 employees complied with NAC 441A.375 regarding tuberculosis (TB) testing for the protection of all residents (Employee #1, no evidence of chest x-ray after positive TB test). This was a repeat deficiency from the 11/6/08 State Licensure survey. Severity: 2 Scope: 3	Y 103		
Y 992 SS=F	449.2756(1)(c) Alzheimer's Fac awake staff NAC 449.2756 1. The administrator of a residential facility which provides care to persons with Alzheimer's disease shall ensure that: (c) At least one member of the staff is awake and on duty at the facility at all times. This Regulation is not met as evidenced by: Surveyor: 28380 Based on observation and interview on 11/20/09, the facility failed to ensure one member of the staff was awake at the facility at all times. Severity: 2 Scope: 3	Y 992		